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Family Planning Digest

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APHA Centennial Meeting

Family Planning Key to Babies', Mothers', Teens' Health; Ethical Concerns Urged

Some 8,600 physicians, nurses, social workers, administrators, systems designers, financial managers and paraprofessionals joined in spirited discussion of a score of family planning and related topics at the centennial annual meeting of the American Public Health Association held in Atlantic City, November 12-16. Topics discussed at this meeting of the nation's largest multidisciplinary health organization, and reported in this issue of *Digest*, include:

- health and social implications of teenage pregnancy,
- role of family planning in reduction of infant mortality,
- postpregnant vasectomies,
- APHA resolutions relating to family planning,
- health of babies born to teenage repeaters,
- Spanish-speaking Americans, prenatal care and family planning,
- comprehensive programs for pregnant adolescents,
- health status of teenagers seeking contraceptive care.

A measure of the importance accorded family planning is the number and variety of resolutions relating to fertility control adopted by the Association's Governing Council.

- In several resolutions, the APHA makes clear its concern with the ethical considerations of research, both research performed on institutionalized persons and research on alternative methods of health care delivery involving whole populations. The resolutions urge that established guidelines on research be followed meticulously, that truly informed consent be obtained and that participation be voluntary, that peer review be welcomed, that all projects be monitored continuously and closely, and that representatives of communities in which research is undertaken be informed of the nature and objectives of the research and that their acceptance be solicited. Apart from obtaining informed consent, one resolution emphasizes that neither employment nor the receipt of health benefits should be made conditional upon participation in research projects.
- In another resolution, the APHA urges swift implementation of "the recommendation of the Commission on Population Growth and the American Future that there be established an Institute for Population Sciences in the National Institutes of Health in 1973." Such an institute would, according to the resolution, "facilitate acquisition of qualified personnel, laboratory and clinical space, and other resources necessary for a diversified program. It would increase the feasibility of the population research program, signal

to the world that it ranks high among our research priorities, and should help in commanding the level of funding that we believe is necessary but which has not been forthcoming."

The Council observes that it had long supported a "vastly increased [population] research effort" which had been provided for in the Family Planning Services and Research Act of 1970. It had recommended that the Center for Population Research of the National Institute of Child Health and Human Development be strengthened to carry out its enlarged responsibilities and be given the status of a discrete institute under the direct supervision of the Director of the National Institutes of Health, so that it would be "better able to bring together and finance presently fragmented research and improve the character of present research efforts of the Federal Government." It notes that this had not been done and that only "a small portion of funds authorized under the Act have been obligated for population research."

• Another resolution urges "the prompt adoption of a National system of health insurance which would place strong emphasis on preventive health services. . . . the provision of fertility control services is fundamental to preventive health care and deserves the highest priority. . . . any national health insurance proposal considered and adopted by Congress must reflect that priority and provide universal coverage of all fertility related health services to all who need them regardless of age, marital or economic status." The resolution concludes by urging that "all organizations which provide health care on a prepaid basis include those services in the basic coverage of benefits to all persons enrolled. . . ."

• One resolution concerns the need to expand the role of the nurse in primary health care, noting that this concept "has gained widespread support from the health community, as well as the public." It adds, however, that there has been "an unplanned proliferation of short-term training programs to prepare nurse-practitioners without the concomitant development of standards to provide adequate safeguards for the practitioner and the public." The resolution recommends that the expanded role be developed jointly by the professionals in medicine and nursing, that guidelines and standards for programs be developed and refined and that experimentation be continued under the auspices of accredited institutions.

• A fifth resolution observes that despite "widespread support [for family planning] and multiple advances toward making such services almost universally available," there remain many unmet needs, such as that of college students for contraceptive services. Noting that the American College Health Association has reported that only a small proportion of colleges and universities offer family planning services to their student population through their college health services or other facilities, the APHA recommends that "college health services offer confidential medical consultation and service on birth control methods, on the diagnosis of pregnancy, and on the diagnosis and treatment of venereal disease."

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MD Cites Dangers of Teenage Pregnancy

The needs of sexually active teenagers for contraceptive information and services, the health problems of presumably healthy teenage girls seeking contraceptive care, the health status of first and subsequent infants borne by unwed teenagers, and comprehensive programs for pregnant adolescents were all considered at various sessions whose overflow audiences attested to the interest in and importance of this aspect of family planning in the view of health workers.

In a wide-ranging review of the health and social consequences of teenage pregnancy, Nicholas H. Wright, M.D., of The Population Council, pointed out:

• Maternal mortality rates for mothers under 20 are about 30 percent higher than for mothers aged 20-24. Maternal deaths

associated with toxemia and septic abortion are 50 percent higher for girls under 20.

• Late fetal death ratios among mothers under 20 are 15 percent higher than among mothers 20-24. The risk of late fetal death for young mothers rises rapidly with increasing parity.

• The baby of a teenage mother has a 30 percent increased risk of dying before its first birthday, compared with the babies of mothers 20-24. The differential risk to second and later live-born children of teenage mothers rises rapidly.

• There is a substantially increased incidence of prematurity among young mothers. Compared to babies born to mothers 20-24, the offspring of women 15-19 were 36 percent more likely to be premature, as measured by weight. The differential is much greater when the mothers are under 15.

• A large proportion of women seeking legal abortions are under 20, many of them unmarried. Because of ambivalence, denial, misinformation and ignorance, this age group tends to come forward later in pregnancy and is thus at risk of higher complication rates.

"Recent estimates developed from the play of infant mortality around maternal age and birth order," Dr. Wright explained, "suggest that the single most effective family planning development with potential for lowering the declining, but still high, U.S. infant mortality rate would be postponement of first births from the teen years to age 20-24. There is little doubt," he continued, "that an extremely dysfunctional reproductive pattern—particularly in the high proportion of total births to young mothers, many of them out-of-wedlock—helped to slow the decline of the U.S. infant mortality rate over the past 20 years."

[Documentation for this point of view

came in another paper presented at the APHA, showing that about one-third of the decline in infant mortality between 1960 and 1968 is attributable to shifts in the age at which mothers gave birth, as well as the number of children they bore. An increasing proportion of births occurred to low-risk mothers, those in their optimal childbearing years, rather than to high-risk younger mothers, among whom infant mortality is considerably higher. And fewer children were borne, as well.

The investigators, led by J. Richard Udry, of the University of North Carolina's School of Public Health, attributed a substantial proportion of the shift in childbearing to the greater availability of family planning.]

Turning to the social consequences of teenage pregnancy, Dr. Wright reiterated research findings that many young couples who legitimate an out-of-wedlock conception by marriage remain economically disadvantaged throughout their lives [see: "Couples Best Off Who Best Plan Number and Spacing of Children," *Digest*, Vol. 1, No. 3, 1972, p. 3]; and that formal education for teenage pregnant girls is often permanently ended, since many schools still do not provide special services for pregnant teenagers and a few punish them by expulsion or stigmatize them by encouraging them to stay in school as "examples." Perhaps the most serious consequence for the unwed teenage mother is that her options are severely curtailed and her "nonfamilial potential" is much less likely to develop, Dr. Wright observed.

Scope of the Problem

The dimension of the problem was underscored by the physician when he pointed out that in the late 1960s about 17 percent of each year's births in the United States—some 600,000—were to women under 20. Of these 600,000 births, 150,000 were second or later births; about 200,000 were conceived out of wedlock and an estimated 165,000 were born out of wedlock, representing about half of all out-of-wedlock births in the United States; in 1971 an estimated 130,000 reported legal abortions were to women under 20. He noted, "Although the proportion of women bearing a child by age 20 had declined in recent years and the specific fertility rate for this age group is low, the number of women at risk—a consequence of higher birthrates in the late 1940s and 1950s—and the number of such births have both increased." Dr. Wright added that by mid-1972 the number of women aged 15-19 reached about 10 million.

A national survey carried out for the Commission on Population Growth and the American Future, Dr. Wright reported, found that although 28 percent of unmarried women aged 15-19 were sexually active, they were strikingly uninformed or misinformed about reproduction and "the 72 percent not sexually active were even less well informed." Less than 20 percent of the sexually active girls always used a method, and frequent chance-taking was quite typical. Among sexually active teenagers, according to Dr. Wright, "the drugstore remains the major source of contraception, with public clinics and private physicians far behind." [For details on the teenage study, see: "28 Percent Have Had Sexual Relations: Half of These Used No Contraception," *Digest*, Vol. 1, No. 5, 1972, p. 6.]

Demand for Education

The physician pointed out that young women themselves deplore their lack of education concerning contraception and sexuality. One group told interviewers that they believed a high school health course, presenting information about sex, reproduction and contraception, would be helpful, and should be given to students by age 15. Elected representatives of New York City's 300,000 high school students told the Board of Education that they believe that "all students have the right to receive information from a personal counselor on abortion, contraception, drugs and the draft without fear that it will be recorded on their records. . . ."

What high school youngsters are actually getting, Dr. Wright said, could be deduced from one sex education curriculum which advised teachers: "Dating is a socially acceptable practice but necking, petting, and sexual intercourse may lead to physical, emotional, and social problems"; the same curriculum stated that questions concerning contraception were to be answered: "There are ways of contraception; however, if you want to know more about this, you should speak with your parent or clergyman."

Reasons for Unmet Needs

Dr. Wright observed that legal and social inhibitions were largely responsible for the failure of family planning programs to meet the birth control needs of sexually active teenagers. Family planning strategies emphasizing postpartum approaches, he pointed out, do not reach the never-pregnant, sexually active teenager. Tightly budgeted, rushed, mass family planning clinics can "only rarely provide the environment and varied special services required by teenagers," he maintained, adding that "where the environment is informal, personal, unhurried and accepting, where there is peer group participation, where the presentation of information on human sexuality and contraception relieves adolescent anxiety . . . and corrects misinformation, and where the essential contraceptive services, VD testing and treatment, pregnancy testing, and abortion counseling and referral are of high quality and confidential, these settings will rapidly be overwhelmed by interested teenagers." [Several different types of clinics serving teens are described in "Teen Family Planning Clinics Meet Urgent Personal, Social Needs," *Digest*, Vol. 1, No. 3, 1972, p. 7.] Dr. Wright observed that "regrettably" in some places it was easier for a teenager to obtain abortion services than it was for her to obtain preventive care. He said that "to let access to information on human sexuality and family planning services for never-pregnant, unmarried teenagers lag behind that available to married or ever-pregnant women and lag behind abortion services in general is *bad* public health."

Dr. Wright pointed out that professional organizations such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, among others, support provision of services to unwed sexually active teenagers, that state and local governments have taken positive action to change restrictive laws and policies, that in February 1972 the U.S. Commissioner of Education urged continuing education and health services for pregnant school girls, that the 1972 Social Security Amendments stress the provision of family planning services to sexually active minors and require that DHEW work with states to move in this direction.

Endangered Infants

Comprehensive programs which provide health, educational and social services for unwed pregnant teenagers until their babies are delivered, and then fail to provide ongoing assistance to these young mothers, are not adequately serving subsequent babies which this at-risk population may bear within a short period. Subsequent children borne by this population within two to three years are at greater risk than the older siblings delivered after their mothers first enrolled in the comprehensive programs. These were the major conclusions from a prospective study made by a team of investigators headed by Dr. James F. Jekel of Yale University's School of Medicine, compar-

ing the health of two groups of babies born to school-age mothers.

The health at birth and in the immediate postpartum period of 180 infants born to 180 girls under 18 years of age and unwed at the time of conception was compared with that of the first 103 subsequent infants born to some of the same mothers, all but two of whom were still teenagers when their subsequent babies were born. The 180 girls received services for their first (study) pregnancy in the Young Mothers Clinic of the Yale-New Haven Hospital between September 1, 1967 and June 30, 1969. All of the 180 and all but two of the 103 subsequent babies were delivered at the Yale-New Haven Hospital, so the sources of data were comparable for almost all the deliveries. By January 31, 1972, 79 of the 180 mothers in the study population had delivered one or more subsequent infants, totaling 103 babies. (In addition, during the follow-up period there were 21 miscarriages, 20 induced legal abortions and one self-induced abortion.)

"The most striking finding," Dr. Jekel reported, "was the significantly higher risk of perinatal mortality and prematurity among the 103 subsequent infants than among the 180 first borns." There were nine perinatal deaths among the 103 subsequent infants compared to two among the 180 first babies, giving the subsequent infants a risk almost eight times that of the study babies. "A difference this large would occur by chance in less than one case in 100," he said. The nine perinatal deaths, the study found, occurred to infants delivered of eight different mothers.

Twenty-eight infants, or 27 percent, of the subsequent deliveries were of low birthweight (less than 2,500 g). This is more than twice the proportion of premature-by-weight infants in the first group. "Low birthweight," the investigators observed, "is associated with, and is presumably a causative factor in, most deaths around the time of birth." All nine of the perinatal deaths among the subsequent deliveries were associated with low birthweight, which ranged from 580 to 2,220 g and only two were over 2,000 g.

Parity was strongly associated with poor outcomes in subsequent pregnancies. The investigators calculated that while the first births had a one percent risk of perinatal death, this rose to seven percent for second births and 14 percent for third births. The risk of prematurity was 11 percent for the first births, 21 percent for second and 43 percent for third.

Prenatal care was also strongly associated with pregnancy outcome. In both the study and subsequent pregnancies, women who made fewer prenatal visits were more likely to produce a premature birth or perinatal death, and the young mothers sought less care for the subsequent pregnancies than they did for the study pregnancy. For the study pregnancy, the average was 7.7 visits, in contrast to 5.1 visits for the subsequent deliveries. Moreover, almost seven percent of subsequent pregnancies received no prenatal care. The perinatal deaths occurred among those with little or no prenatal care, the study found, and of the nine perinatal deaths, two had no visits, five had only one, one had three and one had an unknown number of prenatal visits. "This suggests that lack of prenatal care may have been an important factor in the poor outcomes," Dr. Jekel said.

The girls who had subsequent babies did not differ significantly from non-repeaters, as measured by age, race, religion, socioeconomic status, number in the household, educational goals, welfare status, number of parents in the household, appropriateness of grade level, length of residence in New Haven, or ordinal position in the household. However, there were differences in participation in the special comprehensive program during the study pregnancy. Girls who became pregnant again attended the program fewer days and were less active participants than the girls who did not repeat. "It may be," the investigators hypothesized, "that these differences in participation . . . reflected subtle differences in the social, psychological, and/or environmental factors which made the mothers who repeated less willing or able to seek prenatal care, and affected the outcomes of subsequent pregnancies either directly or through reduced prenatal care."

No Differences Found

The investigators also found that there were no significant differences between the two groups during the study pregnancy. "There is . . . no evidence," they reported, "that, as a group, those mothers who had subsequent babies were biologically inferior to those who did not." Consistent with experience reported frequently in obstetrical literature, however, is the finding that the obstetrical performance during the study pregnancy was a useful predictor of obstetrical performance during the subsequent pregnancies, among both those who had subsequent pregnancies and those who did not.

Summing up their findings, the researchers concluded, "During the past decade, more interest has been focused on providing care for young mothers during their first pregnancies than for young mothers with subsequent pregnancies. This study suggests that the greatest risks are among *subsequent* deliveries to girls still in their teens. . . . greater efforts should be made to reach teenage women with higher parity than one." Follow-through by comprehensive programs to meet the ongoing health needs of sexually active adolescent mothers is essential.

Varied Teen Ills Challenge Clinics

The contraceptive clinic serving adolescents should be prepared to render broader health care than the provision of birth control services, a team of New York City public health specialists advised their colleagues. Many teenagers, they said, are beset by a host of physical and mental ills which often go undiagnosed and untreated. Of 255 single girls aged 11-17 who attended a birth control clinic in upper Manhattan, 63 percent were found to have undiagnosed conditions which required medical care. While "pathology was diagnosed in almost every system examined," according to the team report, authored by Dr. Dolores E. Fiedler and nurse-midwives Dorothea M. Lang and Judy M. Carlson, there was a high incidence of gynecological disorders including vaginitis, cervicitis, cystitis, breast tumors, and uterine and ovarian masses. Four positive serologies (syphilis) were found, one in a girl of 14.

Only six percent of these youngsters were receiving Medicaid or welfare assistance; the rest were members of self-supporting working-class families. Fifty-three percent of the girls were black, 36 percent were white, seven percent were of Latin American descent, the rest were of other ethnic backgrounds. All came to the clinic voluntarily; 31 percent were referred by schools, hospitals and relatives; 60 percent came on the recommendation of friends.

Every teenager registering at the clinic is interviewed privately by a public health nurse who elicits a medical and psychosocial history. The initial physical examination, made by a gynecologist or nurse-midwife, includes a gynecological examination, a pap smear, a gonorrhea culture and syphilis test, and a laboratory work-up including urine examination, hematocrit and sickle cell screening. Referrals are made to appropriate services within the same medical center complex where the contraceptive clinic is located, the authors told *Digest*. Specific appointments are made while the girls are at the contraceptive clinic; whenever possible the appointments are made for the same day. If this is not possible, the girls are given appoint-

ments at some time in the near future, she explained. Since some of the laboratory work-ups necessarily take some time to be completed, the girls are asked to phone the contraceptive clinic to learn the results.

If the initial work-up suggests that a girl may have a sickle cell problem, more elaborate tests are made by specially qualified laboratories to confirm the diagnosis. The affected youngster is then referred to a genetic counseling center where experts explain the nature of the condition and its implications.

Examination at the initial and subsequent visits showed that 161 adolescents had 211 significant medical problems which had not been diagnosed previously, and 135 had psychosocial difficulties. Medical problems included, in addition to gynecological disease, a variety of metabolic, cardiovascular, hematological, urinary tract, gastrointestinal and mammary diseases. Malnutrition was common, and, as noted, venereal infections, both gonorrhea and syphilis, were found, even in this young age group. Some of the girls exhibited multiple pathologies.

Among the psychosocial problems were drug addiction, truancy, alcoholism, school dropout, incest, rape and neurosis. Disruptive family situations were common, and a significant number of girls lived in single-parent homes, with foster parents or in institutions.

Prior to admission to the contraceptive clinic, 47 girls had been pregnant. Of these, 36 had had induced abortions, three had had miscarriages, and eight have living children. Five of the teenagers had been pregnant more than once, and nine were found to be pregnant on initial examination. Thus, more than one out of five of the patient population had been pregnant prior to attending a contraceptive clinic.

"It is obvious," the authors conclude, "that if the teenager is denied access to the contraceptive methods that adults utilize, she is forced to risk an unwanted pregnancy and be labeled 'irresponsible' . . . in fact, seven percent of this clinic's teenagers came for contraceptive advice prior to their first sexual encounter. This demonstrates an admirable sense of responsibility. . . . In view of the findings, it is [our] strong recommendation that contraceptive information and methods be made a part of a comprehensive teenage health service easily available to every teenager, sexually active or not."

Multiservice Projects Neglect Contraception

Although it would appear self-evident that unwed pregnant teenagers urgently need contraceptive services following resolution of their pregnancies, only one-fourth of 128 multiservice comprehensive programs providing education, social services and health care to these girls reported in a recent survey that they provide contraceptive services. Three times as many offered nutrition instruction.

An indication of the priority accorded comprehensive programs in various communities is the size of their budgets: Of the 90 programs reporting usable budget figures, more than half (55 percent) had budgets of $50,000 or less and 19 percent had budgets of $50,000-$99,000. Only one out of four programs had budgets of $100,000 or more. These are some of the findings of a national study of comprehensive programs for pregnant adolescents reported by Michael Baizerman, Haumei Ko and David L. Ellison, all with the University of Pittsburgh Graduate School of Public Health at the time the study was made.

A pretested mailed questionnaire was sent in early 1971 to 150 programs throughout the United States, which represented most such programs in the country. The questionnaires were designed to find out, among other things, where the programs are located, how they operate and what services they provide. One hundred and twenty-eight, or more than eight out of 10 questionnaires, were returned.

Thirty-nine programs (30 percent of the total), are located in the North Central region of the United States, encompassing Illinois, Iowa, Kansas, Michigan, Minnesota, Ohio and Wisconsin. The second largest number of programs, 32, are in the Northeast, including Connecticut, Delaware, Washington, D.C., Maryland, Massachusetts, New Jersey, New York, Pennsylvania and Rhode Island. The Southwest and West, including Arizona, California and New Mexico, reported 29 programs, or 23 percent of the total.

Larger cities were most likely to have programs, the survey found. Almost 57 percent of the programs were in cities with populations of between 100,000 and 999,999 while 31 percent were in cities of 10,000-99,999 population. Eleven percent of programs were located in cities with populations of one million or more. No respondent programs were in cities of between 5,000 and 9,999. [For a previous report on multiservice programs, see: "Pregnant Teenagers Need More, Better Aid," *Digest*, Vol. 1, No. 2, 1972, p. 6.]

No program received all its funds from one source, and between two and four sources typically contributed funds for programs. Forty-two programs received some federal funds, 67 some state funds and 56 some city or county funds. Matching funds were only sometimes a precondition for federal, state or local funding.

The study found that "programs were about twice as likely to report the allocation of funds for education as for health or social services." The largest expenditure was for educational services, with 65 percent of programs allocating over three-fourths of their budgets for this component. Health and social services were at the low end of the scale, with 69 percent

Table 1. Health Services Provided in a Sample of Comprehensive Programs for Pregnant Teenagers

Services	*No. Programs (N= 128)*	*Relative Frequency (%)*
Nutrition Instruction	98	76.6
Family Planning Instruction	93	72.7
Prenatal Health Care	78	60.9
Postpartum Care	63	49.2
Labor and Delivery Care	62	48.4
Breast-Feeding Instructions	61	47.7
Pediatric Care	44	34.4
Natural Childbirth Instruction	42	32.8
Abortion Counseling	35	27.3
Contraceptives Provided	33	25.8
Psychiatric Treatment	32	25.0

of the programs spending one-quarter or less of their budgets on each.

Most of the programs reported that they had the capacity to serve only a relatively small number of teenagers each day. Forty-eight percent of responding programs stated that they could not serve more than 44 teenagers; 31 percent said they could serve between 45 and 104; and only 20 percent said they had the capacity to assist from 105 to more than 150.

Almost all of these comprehensive programs were initiated fairly recently. As of June 1971 almost half had been operational for three years or less, and nine out of 10 of the total number of respondents had been open for five years or less.

Eligibility standards were quite varied and were relatively flexible, with formal referral from a professional not required by seven out of 10 programs.

One important barrier to service utilization, the authors pointed out, is the ignorance of potential clients and of outside professionals about service availability. In this connection, it is noteworthy that only 38 percent of comprehensive programs reported that they were listed in their local telephone directory, and the same percentage said they were listed in a local service directory. About half reported they had a brochure, article or report they could provide to interested parties.

Health Services Provided

The nature of the health services component of these comprehensive programs can be seen in Table 1. The most frequently available health services focused on prenatal care, followed by postpartum and pediatric care. While seven in 10 programs provided family planning education, only one-quarter of them provided services, the authors observed. Most programs which reported health services used the same facility as the education services. The authors said this may be accounted for, "by noting that at least one-half of the health services listed as available were instructional, i.e., could be 'provided' without specialized medical equipment and by someone without specialized health training."

The study revealed that girls were enrolled in the comprehensive program a relatively short time, three-quarters of them for six months or less. This is to be expected, the authors pointed out, given the nature of the service. They noted, however, there is a "certain lack of fit between program goals and the program time available to achieve these goals." Some goals are by their nature long-term: "improved health of the mother, adequate care of the baby, avoiding the cycle of poverty, the prevention of future unwanted pregnancies, and even completion of high school (especially for a 13-year-old mother). To expect that such long-term goals will be achieved [by such a brief] input at this critical time in a young woman's life may be unrealistic. . . . progress made during this period may be lost if continuous follow-up does not persist."

Sources

All resolutions adopted by the Governing Council of the American Public Health Association at its centennial annual meeting in Atlantic City, N.J., Nov. 12-16, 1972, are published in *Governing Council Agenda, Part 2*, the official publication of the Association. The specific resolutions referred to are:

- "Provision of Fertility Related Services under National Health Insurance and Prepaid Health Programs."
- "Expanded Role of the Nurse in Health Care."
- "Contraceptive Services for College Students."
- "Biomedical Experimentation in the Institutional Setting."
- "Ethical Issues in Health Services Research and Development."
- "Population Sciences Institute."

Papers presented at the one-hundredth annual meeting of the American Public Health Association, Atlantic City, N.J., Nov. 12-16, 1972:

D.E. Fiedler, D.M. Lang and J.M. Carlson, "Pathology in the 'Healthy' Teenager."

N.H. Wright, "Adolescent Pregnancy: Health and Social Implications."

M. Baizerman, H. Ko and D. L. Ellison, "National Study of Comprehensive Programs for Pregnant Adolescents."

J.F. Jekel, J.T. Harrison, D.R.E. Bancroft, N.C. Tyler and L.V. Klerman, "A Comparison of the Health of Index and Subsequent Babies Born to School Age Mothers."

J.R. Udry, N.M. Morris and C.L. Chase, "Shifting Age-Parity Distribution of Births and the Decrease in Infant Mortality."

Credits

pp. 1, 14: Ken Heyman; pp. 2, 5: Raphael Soyer, courtesy of Forum Gallery, New York City; p. 7: Bernard Cole, PP-WP; p. 12: R. B. Goodman, Black Star.

Georgia Survey

Doctors and Hospitals Want to Serve Poor

Close to 200 of Georgia's physicians and 33 of the state's hospitals expressed willingness recently to become involved for the first time in the provision of family planning services to medically indigent Georgia women of childbearing age. This is the major finding of a mail survey of 5,000 private doctors and 168 hospital administrators undertaken in the spring and summer of 1972 by the Governor's Special Council on Family Planning, whose purpose it is "to . . . implement and coordinate a comprehensive voluntary family planning program throughout . . . Georgia."

Doctor Replies

A total of 373 usable responses were received to the doctors' questionnaire (seven percent of the original sample), including 27 percent which were anonymous or incomplete. A tabulation of the responses showed the following:

- 154 doctors, of 282 replying to this question, said they were willing to serve in a family planning clinic. All the physicians had been informed in the letter accompanying the questionnaire that the reimbursement rate for clinic service is $25 an hour, and that most clinic sessions last two or three hours.
- 170 doctors, of 274 replying, expressed interest in seeing Medicaid-eligible family planning patients in their private offices.
- 198 doctors, of 282 replying, requested additional information regarding family planning services covered by Medicaid.
- 221 doctors, of 290 replying, asked for a copy of the 1972 amended Medical Consent Act, which permits minors in Georgia to consent for family planning services.
- 90 doctors, of 234 replying, were interested in receiving special training in family planning.

Positive responses to the questionnaire were substantially higher than negative responses in every category but training, where 39 percent of the physicians said they were not interested in receiving special training for family planning, compared with 24 percent who said they were interested.

Hospital Administrators

Of 126 replies received from 168 administrators surveyed, 119, or 70 percent of the original sample, were usable. (Seven were eliminated because the hospitals were inappropriate settings for the delivery of family planning services, were

under construction or had not yet been accredited.) The responses showed the following:

- Very few of the hospitals, only 11 of 118 replying to this question, provided clinic services.
- Only 20 hospitals, of 118 replying, provided information and/or referral services.
- A very large number, however, 83 of the 115 replying, reported that they provided surgical sterilization for patients desiring permanent contraception.

Against this background, the survey found a considerable interest in expanding or instituting new hospital family planning programs:

- 33 hospitals, with neither information nor services, of 96 replying, said they were interested in developing them.
- 51 hospitals, of 113 replying to this question, said they wanted a trained person to visit appropriate patients to discuss family planning and make referrals, and 38 of 109 hospitals wanted help to train staff to perform these functions.
- 34 hospitals, of 109, were interested in "securing a person to speak on family planning matters."
- 82 hospitals, of 114, wanted printed material about family planning and resources for services.
- 75 hospitals, of 107, were interested in "providing sterilization for [Title] IV-A certified individuals on a cost reimbursement basis."

Action taken by the Governor's Council in response to the information derived from the two surveys includes the following:

- Each district health officer received a copy of both the positive and negative responses from physicians in his geographic area to use as a resource for manpower recruitment.
- Physicians desiring training have been referred to two appropriate training centers in the state.
- Specific information requested by physicians has been sent to them.
- State family planning and maternal and child health staffs have been given the names of hospitals willing to have trained consultants come into the hospitals to do family planning education and referrals.
- Printed materials are being prepared under the direction of the Council and will be sent to hospitals requesting such literature.
- Funding support is being developed to enable 10 hospitals located in priority areas, where unmet need is high and provision of services is low, to initiate family planning services.

Sources

Governor's Special Council on Family Planning, Atlanta, Ga.:

Letter and survey questionnaire to physicians, June 14, 1972.

Follow-up letter to physicians, Aug. 18, 1972.

Letter and survey questionnaire to hospital administrators, May 2, 1972.

Follow-up letter to hospital administrators, June 2, 1972.

Summaries of responses to physicians and hospital surveys.

1970 National Fertility Study

Two-Thirds of Catholic Women Use Contraceptives Other Than Rhythm; More than Twice as Many as 15 Years Before

By 1970, more than two-thirds of Roman Catholic women were using methods of birth control other than rhythm— the only method which conforms to Church doctrine. The proportion of white, married Catholic women 18-39 years of age using nonlicit methods has increased from 30 percent in 1955 to 38 percent in 1960, to 51 percent in 1965, and to 68 percent in 1970. The analysis, reported by sociologists Charles F. Westoff and Larry L. Bumpass in *Science*, is based on data from the 1970 National Fertility Study, and comparable studies made in 1955, 1960 and 1965. (Dr. Westoff is codirector of the National Fertility Studies with Norman B. Ryder; the Studies were conducted with the support of the Center for Population Research, NICHD, DHEW.)

The papal encyclical *Humanae Vitae*, reiterating the Catholic Church's proscription of "artificial" methods of birth control, was promulgated in 1968; while the greatest increase in Catholic use of such proscribed methods occurred between 1965 and 1970, leading the authors to observe that the encyclical "has not retarded the increasing defection of Catholic women from this [official] teaching."

Use of proscribed methods is most common among Catholic women in the youngest age groups. The authors found that "among women aged 20 to 24 in the year of each study, the proportion not conforming [to Church doctrine] was 30 percent in 1955, 43 percent five years later, 51 percent by 1965, and 78 percent by 1970." The increase from 1955 to 1970, they reported, "was almost as great for the next two age groups: from 37 to 74 percent for ages 25 to 29 and from 30 to 68 percent for ages 30 to 34."

Westoff and Bumpass find that as Catholic women grow older a larger percentage of them tend to deviate from traditional Church doctrine. Their explanation is that "women tend to adopt more effective methods as they grow older; as a cohort ages, increasing proportions have had all the children they want and thus face the risk of unwanted pregnancies." Observing that women aged 20-24 in 1970 were already at the 78 percent level of nonconformity to official teaching, they conclude: "it seems likely that their birth control practices will become indistinguishable from those of non-Catholics, reaching a maximum of around 90 percent." The other 10 percent, they point out, will include Catholic women who discover they are subfecund and therefore use no birth control, as well as a small fraction who use the rhythm method successfully.

The analysis also shows that education is having a somewhat different effect among younger Catholic women sampled in 1970 than among those sampled in previous years. In 1965, nonconformity was

greatest among Catholic women who had not completed high school, 57 percent of whom used nonlicit methods of birth control, compared with 40 percent of women who had attended college. "By 1970," Westoff and Bumpass report, "this relationship had reversed among younger Catholics, with college women deviating from Church teaching slightly more than women who had not completed high school. . . . The college-educated and the high school-educated are now virtually indistinguishable in terms of birth control

practice. The rhythm method is least popular among the least educated women, but the largest proportion of women who have never used contraception are still found in this group."

In an effort to determine whether the move away from traditional teaching regarding birth control merely reflects attrition from the Church in general, the authors inquired into the degree of religiosity of their sample. Their index of religiosity was the frequency with which a woman received Communion: They regarded those who received it at least once a month as the more committed to the religion (since receiving it with that frequency exceeds the minimum obligation, which is once a year), and those who received it less frequently as the less committed. Westoff and Bumpass find that by this yardstick, "Catholic women . . . are moving away from traditional formal practice, but, much more important for the increase in nonconformity, . . . those women who continue such formal practice are increasingly just ignoring Church teaching on birth control." They report that "in 1970, the majority (53 percent) of the more committed Catholic women were deviating from the official position on birth control, a remarkable increase from the 33 percent so classified in 1965." Only about one-eighth of the increase in nonconformity could be attributed to a decline in religious practice. Even more remarkable, in their view, "is the increase in nonconformity among the younger, more committed Catholic women: from 38 percent in 1965 to 67 percent by 1970."

The use of the pill by Catholic women is an index of their nonconformity on birth control matters: Among Catholic women under 30, its use increased from 20 percent in 1965 to 37 percent in 1970, according to the authors, while rhythm use declined from 38 percent in 1965 to 18 percent in 1970. Westoff and Bumpass conclude from their analysis:

> one consequence of the increasing nonconformity of Catholics in the area of birth control has been to diminish the differences between Catholic and non-Catholic contraceptive practices. In the period between 1965 and 1970, a marked convergence has occurred in the proportion using every method except surgical sterilization. . . . It does not seem at all unlikely that by the end of the decade Catholics and non-Catholics will be virtually indistinguishable in their birth control practices.

Source

C.F. Westoff and L.L. Bumpass, "The Revolution in Birth Control Practices of U.S. Roman Catholics," *Science*, **179**: 41, 1973.

One in Six Couples Who Want No More Children Have Contraceptive Sterilizations

Contraceptive sterilization has risen so rapidly in popularity in the United States in the past few years that the phenomenon is being widely discussed and analyzed in learned journals and at professional meetings. One recent article in *Demography*, by sociologists Larry L. Bumpass and Harriet B. Presser, reports that as of 1970 more than one in six (18 percent) of married couples of reproductive age desiring no more children (couples 'at risk' of unwanted pregnancy) had had contraceptive sterilizations, compared to less than one in eight (12 percent) five years before. The data were derived from a special analysis of the 1965 and 1970 National Fertility Studies (NFS), directed by Charles F. Westoff and Norman B. Ryder of Princeton University and supported by the Center for Population Research, National Institute of Child Health and Human Development, DHEW. The analysis showed that by 1970 vasectomy was slightly more prevalent among couples at risk than was tubal ligation, reversing a trend that had held through 1965. Bumpass and Presser estimate that in 1970 alone about 320,000 vasectomies were performed.

- There is a direct relationship between the prevalence of sterilization and the age of the wife. In 1965, five percent, and in 1970, six percent, of couples at risk with the wife under age 25 had contraceptive sterilizations. In both years the proportion was high among couples where the wife was 25-29 years of age: 11 percent in 1965 and 13 percent in 1970. The greatest prevalence of couples sterilized was found when the wife was 35-39: 15 percent in 1965 and 23 percent in 1970.
- Parity is also related directly to the prevalence of sterilization. In 1965, two percent of couples at risk with one child, and in 1970, six percent, had contraceptive sterilizations. In 1965, eight percent with two children were sterilized, rising to 12 percent in 1970. Among couples with three children, 13 percent in 1965 and 20 percent in 1970 had sterilizations. The highest prevalence was found among couples with six or more children, with 23 percent found sterilized in 1965, compared to 35 percent in 1970.

Other highlights from Bumpass' and Presser's analysis include the following:

- Vasectomy is "extremely rare" among blacks, representing only one percent of the risk population in 1970, compared with nine percent among whites. Tubal ligations, on the other hand, are more than twice as prevalent among blacks as among whites (15 percent compared to six percent).
- Twenty-seven percent of couples at risk whose last birth was unwanted had contraceptive sterilizations as of 1970, compared to 16 percent where there was not an unwanted birth, an increase from 19 and 11 percent, respectively, in 1965.
- As of 1970, women of low education were much more likely to have a tubal ligation than were their husbands to have a vasectomy. For women with higher education it was more likely that the husband was vasectomized. Thus, for at-risk couples where the wife had less than a high school education, 13 percent had tubal ligations and seven percent had vasectomies, whereas, when the wife was a college graduate, four percent had tubal ligations, and nine percent had vasectomies.
- In 1965, among couples at risk where both partners were Protestant 16 percent had contraceptive sterilizations, compared to six percent where both were Catholic. In 1970, 22 percent of Protestant couples and 10 percent of Catholic couples were sterilized.

Bumpass and Presser found that among all couples sterilized since 1965, at the time of sterilization the wife was on average 31.8 years of age, her husband 35.1 years of age. They had been married 11.5 years and had given birth to 2.8 children. They waited 3.9 years after the birth of their last wanted child before sterilization. The authors observe:

> sterilization is not largely confined to the late child-bearing years. Close to one-tenth of recent sterilizations . . . occurred before the wife was 25 . . . and almost another 30 percent occurred when the wife was between 25 and 29 years old. One-fifth of the husbands were under 30 years of age when either they or their wives were sterilized; 50 percent were under 35 years. . . . Over one-fourth of the sterilized couples had given birth to no more than two children; and over 50 percent had no more than three children.

The two authors also found (in another recent article also analyzing NFS data) that couples sterilized since 1965 "tended to use the most effective methods of contraception prior to their adoption of sterilization." Fifty-one percent used the pill or the IUD as their most recent method, 15 percent more employed the diaphragm or condom, and 11 percent used other methods; 22 percent, however, reported

using no contraception in the interval preceding or following the last birth prior to becoming sterilized.

Sources

L.L. Bumpass and H.B. Presser, "Contraceptive Sterilization in the U.S.: 1965 and 1970," *Demography*, **9**: 531, 1972.

H.B. Presser and L.L. Bumpass, "The Acceptability of Contraceptive Sterilization among U.S. Couples: 1970," *Family Planning Perspectives*, Vol. 4, No. 4, 1972, p. 18.

Vasectomy Choice of Young Texas Couples

Many Texas couples who selected vasectomy in 1971 to terminate childbearing were under 30, a recent study from a Fort Worth vasectomy clinic found, with wives averaging 27 years of age and husbands 30. While younger than the national sample described by Bumpass and Presser (above), they are also overwhelmingly white and middle-class. They have an average of three children and the majority were practicing birth control just prior to the vasectomy. Just under half were using the medical methods of contraception but almost one-quarter were using no method, although they clearly wanted no more children. These are some of the findings of a study of husbands and wives made prior to the vasectomy and then 10 weeks following the operation, reported by Steven G. Cole and Davis Bryon, who are associated with the Institute of Behavioral Research of Texas Christian University in Fort Worth.

One hundred and sixty-nine couples completed a preoperative questionnaire at the counseling session they attended between March 24 and September 24, 1971 at the Fort Worth Vasectomy Clinic, which is a unit of the John Peter Smith Hospital Family Planning Clinic. An analysis of the data showed that about 35 percent of the couples had two or fewer children, about 39 percent had three and just over 26 percent had four or more. Seven out of 10 of the men decided to have a vasectomy because they didn't want any more children, and wanted to limit the size of their families. About one of six men said they wanted the procedure to protect the health of their wives, and one out of eight said they chose vasectomy because it was the safest and best or most permanent method of birth control. That they chose the method thoughtfully is suggested by the fact that they took an average of 14 months to decide on it.

Six out of 10 of the men said they heard about the vasectomy clinic from friends, relatives, spouse or their family doctor, while one out of five learned about its existence from community agencies such as Planned Parenthood or the health department. Seven out of 10 had not talked to a private physician about vasectomy, and nine out of 10 came to the clinic because of cost factors. About one in 12 said that the physician they consulted either refused to perform the vasectomy or didn't perform this particular operation.

About 40 percent of the men said they had relatives who had had a vasectomy—a brother, brother-in-law, father, uncle or cousin—and more than three out of four had a friend who had had one. Almost nine out of 10 men said their friends had recommended the operation. Virtually all the men—97.6 percent—said their wives agreed with the decision to have a vasectomy.

From the wives' responses also, it is clear that they agreed overwhelmingly with their husbands on the advisability of vasectomy, and eight out of 10 of them said both felt equally strongly that the operation was desirable. Like their husbands, more than half the women had heard about the operation from other people; the next major source of information was community agencies—and this was also true of the way they learned of the vasectomy clinic at the hospital. Eight out of 10 of the wives were full-time homemakers, and the same proportion of men were employed full-time outside the home.

Postoperative Responses

About two-and-one-half months after the vasectomy, six out of 10 of both husbands and wives said they felt very positive about vasectomy as a method of birth control, describing it as the "best." About one out of four wives said that prior to the operation their major worry was about its psychological effect upon their husband, and one of five was concerned about the pain he might experience. A few, about six percent, said they were concerned prior to the operation about whether it would really be a permanent method. Four out of 10, however, said they had no concerns about the operation before it took place. Almost two-thirds said afterwards that they felt there was no basis for their worries. Just under two percent said they felt worse about vasectomy after their husbands had experienced one than they had beforehand.

The vast majority of men (94.5 percent of 110 who answered the question) said the procedure caused them no problems, and just under half said that it was only "slightly" painful, comparing it to having a tooth pulled or getting an injection. Almost nine out of 10 experienced some pain, lasting an average of eight days. While three out of four said the vasectomy had no effect on their job performance, almost all (96.3 percent) said it partially restricted their activities for a while. While two-thirds of the men said they didn't feel different in any way from the way they did before the operation, of those who did feel different, nine out of 10 said they felt better, with increased peace of mind, less worry and enhanced sexuality.

The men had little reticence about discussing vasectomy with friends, and more than nine out of 10 said others knew they had had the operation. Within a short period following the vasectomy, more than eight out of 10 men had already recommended it to their friends.

Source

S.G. Cole and D. Bryon, "Couples Served by the Fort Worth Vasectomy Clinic: An Evaluative Examination," 1972 (mimeo).

Pill-Related Deaths: Are They Declining?

Recent data on possible drug-related deaths in England afford "highly suggestive evidence that mortality related to the pill has decreased materially," according to Dr. A.M. Adelstein, Chief Medical Statistician of the Office of Population Censuses and Surveys, which maintains records of suspected drug-related mortality in the United Kingdom.

In 1968, the oral contraceptives were implicated on death certificates as a possible cause of 17 deaths. In 1969, the number rose to 28. In 1970, however, only 13 such deaths were reported. Dr. Adelstein suggests that the sharp rise to 28 "reflects better information about the subject," with consequent better reporting; while the subsequent decrease might be due to more women taking low-dose estrogen pills following widespread publicity given studies which found that combination pills containing such lower doses were safer than those with higher estrogen content. He also notes that some of the reduction might have been due to a decrease in the number of women using the oral contraceptive. (The use of oral contraceptives in England has now returned to the level reported before the adverse findings of 1969, according to the International Planned Parenthood Federation.)

Sources

A.M. Adelstein, "The Medical Division of the Office of Population Censuses and Surveys, Part I.—Objectives and Methods," *Health Trends*, **4**:2, 1972.

"Is the Pill Getting Safer?" *IPPF Medical Bulletin*, Vol. 6, No. 3, 1972, p. 4.

Resources in Review

By Dorothy L. Millstone

A stream of new audiovisual and printed materials dealing with various aspects of fertility control provides an opportunity and stimulus for the creative teacher to include this subject in many curriculum slots. The arithmetic of population growth, the history of birth control and its relation to social change and technological developments, the changing role of woman in Western culture and the part played by contraception, the biology and physiology of reproduction, the stimulating and provocative readings in historical and contemporary demography—all these and more can be stimulated by the materials produced by knowledgeable and sensitive authorities in many fields.

Birth Control Textbook

Contraception By Choice or By Chance (1972) is campus-bound, judging by its vocabulary and the knowledge it assumes in its readers. A light touch lifts its strictly method-approach to family planning and may make it more attractive to students than some other manuals. Written by Stephen Bender and Stanford Fellers of San Diego State College, this book has the advantage of putting contraception into the framework of health education. It is published as part of the Contemporary Topics in Health Science Series. Earlier companion volumes deal with such topics as exercise, alcohol, drugs and mental health. If secondary school teachers develop their own glossaries and teaching plans, they might be able to adapt this to junior and senior high schools.

Purchase price: 95¢, from William C. Brown Company, 135 S. Locust St., Dubuque, Iowa 52001.

Family Planning, 'True Story' Style

True to Life (1972) is an unusual approach to consumer family planning education. Teaching is infused in fiction written in the vein of mass-circulation pulp romance magazines. The purpose of the publication, issued by the Emory University Medical School, is to reach readers of such magazines with sound health information they might not ever see otherwise. A striking four-color cover with sensational headlines ("A Young Wife's Burden: Did Vietnam Kill My Husband—Or Did I?" for example) typifies the fidelity with which this 64-page magazine adheres to a true-confession type of format in an attempt to reach the same readership. An earlier, briefer, experimental edition along the same lines won national publicity and was widely used. The new version appears in an edition of 100,000.

A Young Wife's Burden:
DID VIETNAM KILL MY HUSBAND--OR DID I?
TRUE TO LIFE
I ALMOST KILLED MY BABY TO KEEP MY HUSBAND!!!
WE'D HAD TWO CHILDREN--BUT WE'D NEVER MADE LOVE!
BOTH OF US WANTED AN ABORTION—BUT ONLY ONE OF US WAS PREGNANT!!!

Purchase price: 50¢ (orders in volume bring the unit price down to as low as 8¢), from Felicia Guest, Box 26069, 80 Butler St., S.E., Atlanta, Ga. 30303.

Training Sex Educators

A lack of trained teachers has long obstructed systematic development of sex education on the same level as other school curricula. *The Professional Training and Preparation of Sex Educators* (1972) was prepared by the Training and Standards Committee of the American Association of Sex Educators and Counselors (AASEC) as a step toward meeting this need. This booklet spells out the training plan its authors deem essential to make sex education a recognized professional specialty. No detailed curriculum is presented, but the authors outline the subject areas they consider necessary for the knowledgeable educator.

Purchase price: 65¢ (discounts for orders in quantity), from AASEC, 815 15th St., N.W., Washington, D.C. 20005.

Research Made Easier

The Students' Guide to Marriage and Family Life Literature (fifth edition, 1972) is prepackaged research prepared for a college-level audience. It may be of use also to secondary school teachers. Authors Lester A. Kirkendall and Wesley J. Adams combed 433 books, journals and other publications for authoritative studies related to their field. They catalogued these by chapter and page, and keyed them to study subjects so that if you want to write a paper on family planning, for example, you can look the subject up in their index, find it listed under reproduction and health in a section on marriage, and be led immediately to the books, chapters and pages where the background material they recommend for this subject can be found. A selected list of 30 basic reference works is provided. A self-quiz permits the researcher to check his own learning with true-false keys. Another spur to independent learning comes through the book's attitudinal checklist. Students who register their own attitudes before they embark on study will be able to check what they have learned by repeating the experience *after* they have done the suggested reading. Learning how to use this paperback guide well may take a full hour, but it is worth it.

Purchase price: $3.50, from William C. Brown Company, see above.

Audio-Visual Catalogues

Two impressive film guides will make life easier for the family planning and sex educator:

• *Sex Education on Film* (1971), a paperback published by Teachers College of Columbia University, catalogues 8mm and 16mm films, filmstrips and transparencies, organized under subject headings, keyed for age of audience and evaluated as to content and teaching effectiveness. Evaluations are candid (for example, "long and boring," in one case, and "Adequate but disappointing" in another). A sample program in sex education, geared for parents and teenagers, is included.

Purchase price: $3.95, from Teachers College Press, Columbia University, New York, N.Y. 10027.

• *Film Resources for Sex Education* (1971) in contrast, comes in a loose-leaf binder and SIECUS, its publisher, accepts the obligation to send revisions and new information regularly so that the catalogue may be kept up-to-date, a boon in a field in which new movies are proliferating.

As in the Teachers College guide, films, filmstrips and transparencies are listed, dated, keyed for subject and audience age level, and evaluated. The SIECUS guide collates reviews published individually in various issues of the organization's newsletter. Evaluations are mostly by staff members, but they are not signed. Dr. Laura Singer, Teachers College professor, and her coauthor, Judith Buskin, by contrast, have reviewed all the films in the Teachers College catalogue themselves so that users may find it easier to assess their evaluations and discover their criteria.

Some 68 films are listed in both catalogues. Each contains a substantial number not in the other. If only one can be bought, the loose-leaf is the better buy.

Purchase price: $1.50, from the Sex Information and Educational Council of the U.S. (SIECUS), Publications Office, 1855 Broadway, New York, N.Y. 10023.

Guiding the Mentally Retarded

A Resource Guide in Sex Education for the Mentally Retarded (1971) is designed for professionals and parents. This booklet was prepared jointly by SIECUS and the American Association for Health, Physical Education and Recreation (AAHPER). Subject areas include: teaching styles and sample lessons; curriculum concepts; suggested activities, and resource materials and catalogues of printed materials and audio-visual aids keyed for adult use to supplement their own knowledge. Conception, contraception and sterilization are dealt with in the section, "Physical changes and understanding of self."

Very few of the listed resources were developed specifically for use with or by the mentally retarded. All are coded for links to specific topics and levels of difficulty in language and concepts. A list of organizations and agencies which provide services and produce materials for use in sex education for the mentally retarded is included.

Purchase price: $2, from SIECUS (address above) or AAHPER, 1201 16th St., N.W., Washington, D.C. 20036.

Reviewing Teenage Programs

Teenage Pregnancy, Prevention and Treatment (1971), a 28-page study guide for professionals and parents, briefly defines the scope of the problem, identifies chief gaps in essential service and summarizes specific, representative programs in education and health care for the pregnant young girl, and in contraceptive and sex education for young people at risk of pregnancy. Philip M. Sarrel, M.D., who wrote this booklet, is Executive Director of the New Haven Young Mothers Program and Director of Yale University's sex counseling service. He draws on the practical experience of a variety of projects ranging from those serving the junior and senior high school population to those on the college campus. A reference list and selected bibliography enhance this booklet's usefulness.

Purchase price: 50¢, from SIECUS, address given above.

Teenagers and the Law

• In *The Rights of Teenagers as Patients*, author Theodore Irwin examines the controversy over whether minors should have the right to obtain needed medical and related services without parental approval. What and who are minors, their health needs, parents' responsibilities and concerns, the legal framework and a trend toward liberalization of the law are among the chief subjects treated. Family planners will find this helpful. The greatest progress in legal rights of teenagers to obtain health care has been and continues to be in the area of birth control, the booklet notes, and the new approaches taken by states are briefly analyzed. This folder is No. 480 in the Public Affairs pamphlet series.

Purchase price: 35¢ (discounts for orders in quantity), from Public Affairs Pamphlets, 381 Park Ave., New York, N.Y. 10016.

Education and Pregnancy

Four new booklets from the Consortium on Early Childbearing and Childrearing tell how to begin, finance and operate programs to guarantee continuity in education for pregnant teenagers. School systems and public and private social service agencies will find these colorful, concise, practical monographs of value.

• *Beginning a Program for Pregnant School-Age Girls* defines the essentials of a broad service. Initiatives, the booklet suggests, should start with accumulation of statistics in a given community on the extent of pregnancy among girls under 16 (the age limit most states set for compulsory school attendance). Suggestions are made on components of the health, education and social services that should be included in the special program, and the booklet points out that for planning purposes it is important to find out whether the girls knew about birth control and whether they were able to obtain it in their communities. Where the figures show a need for a special project, the booklet's procedural recommendations point the way to gaining community support and financing to bring it into existence and keep it going.

• *How Communities Finance Programs for Pregnant School-Age Girls*, describes formats already operating in some cities (for example, a coordinated program operated jointly by several social agencies, or reassignment of a teacher of the homebound to meet regularly with pregnant girls at a central location). This booklet also provides specifics about types of funding available generally, and suitable to a variety of project designs. Among the many sources of funding mentioned is the National Center for Family Planning Services.

• *A Discussion of State Laws and State and Local Policies as They Relate to Education of Pregnant School-Age Girls* includes a preface by S.P. Marland, Jr., former U.S. Commissioner of Education, stating that the Office of Education "strongly urges school systems to provide continuing education for girls who become pregnant," and promising to help administrators and their communities to get them going. This booklet provides model state laws and policies and model city school board policy statements.

• *Model Components of Programs for Pregnant School-Age Girls* defines a minimum project—continuing classroom education plus prenatal and postpartum health services and counseling on pregnancy causes and consequences. It then moves along to review additional program elements, drawn from the experience of ongoing projects. Particularly useful are this booklet's charts comparing the advantages and disadvantages of setting the education in the regular school, in other than the regular school and in the special school focused only on pregnant girls. Other charts make it easy to compare the pros and cons of meeting health needs through traditional public and private medical systems, through special-focus health programs within these systems, and through health services organized solely for pregnant girls. Social service components similarly are assessed in charts comparing administration through the regular system, as a special-focus project within the system, and as organized only for pregnant girls. In several charts the importance of birth control service for this group is stressed.

The set of four booklets may be obtained free from the Consortium on Early Childbearing and Childrearing, Suite 618, 1146 19th St., N.W., Washington, D.C. 20003.

About Sterilization

Vasectomy (1972) is a manual for professionals, fourth in a series issued by the International Planned Parenthood Federation (IPPF). [Earlier manuals in the series deal with intrauterine contraception, systemic contraception and abortion, and the first and third were described in *Digest*, Vol. 1, No. 4, 1972, p. 15.] *Vasectomy* details the operative techniques, advises on possible complications and side effects, and records the procedure to check the operation to be sure sperm have disappeared from the ejaculate. A final section discusses reanastomosis, restoring the continuity of the vas after surgery. Anatomical diagrams and charts reinforce the manual's text.

Purchase price: 80¢, from IPPF, 18-20 Lower Regent St., London SW1Y 4PW, England.

Vasectomy Overview

A Sourcebook of Vasectomy (1972) approaches vasectomy from a broader perspective. This book seeks to give an overview of male sterilization in the framework of history and legal, surgical and psychosocial information. Against this background, the practical recent experience of the Fort Worth vasectomy clinic and a half-dozen others, mostly in Texas, is summarized. Of special interest is a tabulation of the comments of men following surgery, recounting their reactions and attitudes toward the operation and the clinic procedures (see p. 9).

Those considering establishment of a vasectomy clinic will find this volume helpful. Those who already operate a vasectomy service may find a plus in checking their experience against that recorded in Fort Worth, Dallas, Houston and other communities.

Purchase price: $6.00, from the Director, Institute of Behavioral Research, Texas Christian University, Fort Worth, Texas 76129.

Infertility Therapy

How to Organize a Basic Study of the Infertile Couple (1971) is a guide for professionals prepared by the American Fertility Society, the learned organization in this field. Procedures are presented for the physician embarking on infertility investigation and treatment. Various steps are outlined and dealt with explicitly: history-taking, physical examination and laboratory studies of the wife and the husband; evaluation of seminal, cervical, uterine, tubal and peritoneal factors, and evaluation of ovarian activity. A summary chart, listing each step in the investigatory procedure with the question each is expected to answer, presents a systematic work plan for the physician.

Purchase price: 50¢, from The American Fertility Society, 1801 Ninth Ave. South, Suite 101, Birmingham, Ala. 35205.

• Note—Readers are urged to send their own materials for review. Send two copies of each item; define the intended audience and goal, state the price and how *Digest* readers may obtain copies. Contributions should be addressed to:

Resources in Review
Family Planning Digest
Room 12A-33
5600 Fishers Lane
Rockville, Md. 20852

Campus Clinic Gift Of Hawaii Seniors

Some 700 University of Hawaii coeds received medical birth control services last year at a weekly on-campus family planning clinic, thanks to a $2,500 gift from the 1970 senior class. The clinic and the unusual gift which led to its organization are described by Eleanore C. Nordyke, the nurse family planning coordinator, and Charles B. Odom, M.D.

It is a custom on many college campuses for the graduating class to bequeath a gift to the college. Traditionally, this gift takes the form of a bench, a plaque, a donation toward a new building or the planting of a tree as a living memorial. But the University of Hawaii seniors—by a 90 percent vote—gave their perhaps unprecedented gift in order to "provide information, services, and supplies for effective reproductive control, to enable students to realize their own desires in regard to number and spacing of children and to insure that education need not be interrupted or limited by an unwanted pregnancy."

The university administration, while not giving outright endorsement to the project, gave it "tacit approval," according to the article's authors. As a result, the clinic was housed on campus as proposed, but under separate administration and financing. Despite the administrators' gingerly response, support for the program was immediate. Student and community newspapers publicized the clinic, and a number of campus groups and students in the School of Public Health contributed manpower and materials to promote it. A descriptive brochure was distributed to all students and posters were placed on bulletin boards.

Because the senior class gift was not sufficient to maintain the clinic, the student association and several pharmaceutical companies contributed additional financial aid and supplies. Later, a fee schedule was agreed upon (based on the Hawaii Planned Parenthood fee) but no one has been turned away because of inability to pay. A deficit of $150 a week is offset by donations from the student association and the American Cancer Society. Payroll expenses are for two physicians, two nurses, two clerks and a health educator.

The clinic's director is a member of the faculty of the School of Medicine's Department of Obstetrics and Gynecology. An advisory council includes students, faculty and administrators drawn from the Schools of Nursing, Public Health, Medicine and Social Work, as well as representatives of the clergy and of the Hawaii Medical Association and the East-West Center Population Institute.

Any member of the university community—student, faculty or any other employee—is eligible for the service, but last year the majority of the recipients were single (86 percent), undergraduates (71 percent) and younger than 25 (91 percent). No one is excluded on the basis of age, and parental permission is not required. By the end of the first year the clinic had provided contraceptive services to 695 patients.

Among the medical services provided at the clinic is a physical examination of the breast, abdomen and pelvic organs. Routine laboratory work includes urinalysis and a pap smear. Other laboratory tests are available (pregnancy test, hematocrit, gonorrhea smears and culture, and serologic test for syphilis). Infertility problems are referred to community physicians. Abortion counseling and referral are also provided. All methods of contraception are made available, but 82 percent of the clinic's patients last year chose pills.

From a survey of clinic patients, it was found that most have intercourse more than once a week. "Coital activity of this frequency," the authors conclude, "validates the need for organized campus contraceptive service." They expect the clinic soon to be incorporated into the regular student health program and thus provide the easier accessibility needed.

Source

E. C. Nordyke and C. B. Odom, "A Family Planning Clinic on Campus: First Year Experience at the University of Hawaii," *American Journal of Public Health*, **62**:1249, 1972.

Britain

Expansion Plan Calls for Free Contraception For All Pregnant Over the Previous Year

"A substantial expansion [of family planning services] is needed if the numbers of unwanted pregnancies [in Britain] are to be reduced. With modern contraceptive methods available there should be fewer abortions and much less of the unhappiness and ill-health which results from unplanned pregnancies." With this explanation, Sir Keith Joseph, Britain's Secretary of State for Social Services, announced his government's plan for a broad expansion of support for family planning scheduled to begin in April 1974. The plan was submitted by the Secretary to meet the family planning requirement of the proposed National Health Service Reorganization Bill, now being considered by Parliament.

The plan includes the following provisions:

- Contraceptive information and services will be provided without charge under the National Health Service to all women who have had a baby or an abortion within the previous 12 months, and to all others "who have a special social . . . or financial need." [While postpartum and postabortal contraception is often made available without charge in the United States to those in need of subsidized services, the noneconomic criterion for free service in the British bill is unique.]
- The number of clinics will be expanded, as will home-visiting services for those who prefer to receive assistance in their homes.
- Physicians will be paid from government funds if "satisfactory arrangements" can be made for the family planning services they render, whether or not their patients have a "medical need" for contraception. At present, services are paid for by the National Health Service only when there is a special medical need.
- Hospitals will be encouraged to broaden their participation by providing family planning information and services to all, and particularly to postpartum and postabortal patients.
- Expanded funding will be available for information and education programs directed to the general public and professional workers.
- The cost of the new plan is expected to be about three times higher a year than at present, rising from an estimated $9.6 million a year to $28.8 million. Over the first four years the plan will cost about $48 million, according to Sir Keith.

The proposal was sharply criticized within Parliament and by British family planning proponents for its failure to make *services* (as distinct from *information*) universally available without charge. An amendment passed in the House of Lords provides that family planning services, including medical examination, prescription of contraception and contraceptive supplies, be provided free of charge to all persons married and unmarried. Lady Shirley Summerskill, a Labour member of Parliament, summed up the criticism of the government's plan in these words:

> It is shutting the stable door after the horse has bolted—to provide free family planning to women who have already had an abortion and to women who have already had an illegitimate child . . . that is, those who fall in the rather vague category of social need. The only fair and effective family planning service would be one which was available free of charge and easily accessible to every man and woman, whether married or unmarried, healthy or sick, and whether they had no children or six children.

In commenting on the government proposal, a *Lancet* editorial observed that while free advice, more clinics and more home services are welcome, "unless free advice is followed by free supplies the old deterrent [to utilization of family planning] will operate." The medical journal deplored the continued practice of allowing physicians to charge patients for service unless they had a compelling health reason for avoiding pregnancy. "The pity here is that such an arrangement acquiesces in the continued setting apart of family planning. . . . The time is long past when such guidance should be accepted as a normal part of the family doctor's help—not as something extra and special."

The *British Medical Journal* also questioned the limitation on free service to those who have a special social or financial need on the grounds that this forces physicians to make judgments they should not be required to make.

The Chairman of the British Birth Control Campaign is reported by the *Manchester Guardian* to have said that the limited extension of free family planning services would eliminate one unwanted pregnancy in 10, whereas completely free services would prevent three-quarters of the unwanted pregnancies.

Men, too, are included in the British government's effort to make fertility control services more generally available. On October 23, an "overwhelming majority" of Parliament, according to the *British Medical Journal*, voted to include voluntary vasectomy in National Health Service coverage. This means that the government subsidizes the cost of vasectomy as it does most other medical services.

Sources

"Contraception for the Needy," *British Medical Journal*, **4**: 688, 1972.

C. Eade, "Contraceptive Help and Supplies Go On National Health," *Manchester Guardian*, Dec. 13, 1972.

"Family Planning in the N.H.S.," *Lancet*, **2**:1350, 1972.

"Free Contraceptives on Basis of Social Need: More Clinics," *The Times* (London), Dec. 13, 1972, p. 12.

"Supplies Should be Free for Everyone," *The Times* (London), Dec. 13, 1972, p. 12.

"Vasectomy Bill Passed," *British Medical Journal*, **4**: 246, 1972.

Clinic Dropouts

Still Contracepting, But Less Effectively

A study of dropouts from one Maryland county's family planning program indicated that while the majority of patients who discontinued clinic attendance still used some method of contraception, many switched to less reliable methods after leaving the clinic and several had unwanted pregnancies. The study also suggested that patients who are not married and who have had few previous pregnancies may be more likely to drop out than those who are currently married and who have had numerous previous pregnancies.

Drs. David S. Bachman and Gary R. Snyder, of the Center for Disease Control in Atlanta, and J. King B. E. Seegar, Jr., of the Maryland State Department of Health and Mental Hygiene, reported on the results of their study in the *Maryland State Medical Journal*.

The investigators compared the 525 "active" and the 58 "inactive" patients on the clinic's roster as of April 25, 1969. Inactive patients were defined as all women on oral contraceptives more than 30 days late for their appointments, and all other patients more than 90 days late. Patients who had notified the clinic that they were moving or leaving the program because they wanted a pregnancy were not included. Half of the dropouts were found to be from one to three months late,

the remainder up to nine months late. Twenty-five of the 58 dropouts had not returned to the clinic after their first visit.

A comparison of the records of the inactive and continuing patients showed no significant difference in their demographic, socioeconomic, sociocultural or health characteristics, except that the inactive patients were more likely to be single or separated and to have had fewer previous pregnancies than the active patients. Thus, 28 percent of the dropouts were single or separated and 69 percent were married, compared to 13 percent and 85 percent, respectively, for the active patients. Those who discontinued also had had fewer previous pregnancies. Thus, 15 percent of the dropouts had had four or more previous pregnancies, compared to 30 percent of the active patients.

Each of the clinic dropouts who could be located was personally interviewed. Attempts were made to locate them by letter and telephone, by questioning relatives, employers, neighbors, landlords and finance companies. At least five attempts were made to visit each woman at home in the daytime and in the evening before giving up. Thirty-eight women (two-thirds of the dropouts) were interviewed. One was confined to a mental institution; three had moved out of the state; three had moved without leaving a forwarding address; and eight could never be found at home. No significant difference was found in the characteristics of those who were interviewed and those lost to follow-up.

When they last visited the clinic, 34 of the women interviewed had been on oral contraception, three had IUDs and one was using foam. At the time of interview, the three IUD patients still had their devices in place. Of the pill users, only 15 were still taking them; six had switched to foam, six were using such methods as condom, douche, withdrawal and rhythm, three said that they were not sexually active, and five said they were using no contraception. Of the latter at least three, and "probably" four, were pregnant, only one intentionally. The sharp rise in pill discontinuation was attributed by the women to side effects or fear of future damage to their health (e.g., cancer).

A series of open-ended questions about reasons for dropping out elicited a variety of responses. The most frequent complaint was long waiting periods and inconvenient clinic hours. The investigators pointed out that waiting times reported ranged from 15 minutes to more than five hours, with a median waiting period of two-and-one-half hours.

To decrease the proportion of dropouts, the authors recommend shortening wait-in periods, initiating Saturday and evening clinics and giving more attention initially to unmarried women and those who have had few previous pregnancies.

Source

D.S. Bachman, G.R. Snyder and J.K.B.E. Seegar, Jr., "A Study of Women Who Discontinue Family Planning Clinic Attendance," *Maryland State Medical Journal*, Vol. 21, No. 3, 1972, p. 28.

Mexican-American Mothers

Lack Prenatal, Family Planning Care; Blame Clinic Organization

Lack of education concerning the importance of prenatal care and family planning to maternal and infant health, as well as lack of transportation to clinics, long waits there, poorly scheduled clinic hours and babysitting problems were the major reasons given by Mexican-American women for their failure to obtain these health services, according to a study made by a team of investigators led by Dr. C.E. Gibbs, and reported by him at the 1972 centennial annual meeting of the American Public Health Association held in Atlantic City, New Jersey.

Concern over the "extremely high" maternal and perinatal morbidity and mortality among the medically indigent women served by the Bexar County Hospital District in San Antonio (in 1969 maternal mortality was 160 per 100,000 births, perinatal mortality was 42 per 1,000 live births and 12.5 percent of newborns weighed less than 2,500 g), led to the study of the patient population in an attempt to discover why the various clinic facilities were underutilized. Every other patient registered for delivery over a one-year period, from April 1, 1969 to March 30, 1970, was selected for interview, and approximately 1,500 usable schedules were obtained, accounting for 84 percent of all those interviewed. In addition, 381 consecutive patients were interviewed between November 1, 1969 and January 31, 1970 to obtain information about family planning behavior.

Almost eight out of 10 of the sample were Spanish-speaking Americans, two-thirds were married, the rest were either single or separated. The vast majority, 85 percent, were self-supporting; and 27 percent of the women had five or more children. Sixteen percent were under 18 years of age. Four percent were members of migrant farm families.

Almost 13 percent of 1,523 women had no prenatal care at all, and another 49 percent made their initial antepartum visit after 20 weeks' gestation. "Patients usually sought medical attention first for confirmation of the pregnancy," Dr. Gibbs reported, "or for treatment of a specific symptom rather than simply to initiate medical supervision of their pregnancy." The two most common patterns of antepartum care, analysis of the data showed, were women who made one to three visits after 32 weeks, and those who sought care early for a specific symptom and then did not return again until near term.

Examination of the data documented the relationship between antepartum care and pregnancy outcome. Among those who received no prenatal care, there was

a 44 percent rate of major obstetrical complications, while among those who received early or delayed care (in the first trimester or in the second) the rate was around 35 percent. The most common obstetrical complication was hypertensive toxemia, which occurred in 16 percent of all the patients and in 25 percent of those under 18 years of age. The effect on perinatal mortality was even more striking. Among those who received no care, perinatal mortality was 70 per 1,000 live births; this fell to half that among those who delayed prenatal care; among those who obtained early prenatal care, perinatal mortality was 20 per 1,000 live births. Respiratory distress syndrome was the most frequent cause of perinatal mortality.

Two-thirds of the women reported that situational factors accounted for their unwillingness to utilize antepartum services. The obstacle most frequently cited was lack of transportation and difficulty in obtaining it, and this was followed by problems with obtaining care for their children while they were attending a clinic, cost of services and long waits or inconvenient scheduling of clinic hours.

For the rest of the women, the greatest obstacle to obtaining prenatal care was "strong concern or fear" regarding physical examinations, the study found. Personal apathy or indifference were often given as reasons, and among very young patients, 14 years of age and under, the desire to conceal a pregnancy was an important factor.

Family Planning Practices

Although 42 percent of the patients or their sexual partners had used a medically recognized contraceptive, usually the pill, it had been discontinued prior to the current pregnancy for such nonmedical reasons as supply problems, concern over its safety and confusion as to proper use. Virtually all the women wanted to limit the size of their families.

The investigators found that, contrary to widely-held assumptions among health professionals, neither machismo, religious belief nor desire for large families were significant deterrents to contraceptive use. Less than seven percent of the women reported any resistance by their spouses, and more than 90 percent "indicated a desire to employ contraceptives or to be sterilized. . . ." When asked for ways to improve the health of mothers and babies, the most frequent suggestion from the women was for education about the importance of antepartum care and family planning. Young women under 18 years of age were "especially vocal" about family planning health services.

Dr. Gibbs concluded by observing that although antepartum care was not much utilized by many women in the study, "the effort required for many . . . to obtain [such] care was enormous. The situational impediments which had to be overcome demonstrated that nothing less than a dogged determination was necessary to get it at all. . . . [In view of these impediments] one may well wonder why so many obtained as much care as they did."

Source

C.E. Gibbs, H.W. Martin and M. Gutierrez, "Patterns of Reproductive Health Care Among the Poor of San Antonio, Texas," paper presented at the centennial annual meeting of the American Public Health Association, held in Atlantic City, N.J., Nov. 16, 1972.

Very Young Mothers Bear More Children

A seven-year follow-up study of two groups of young black mothers and their offspring found that girls who bear their first child at age 15 or younger are more than three times as likely to have three or more additional children in the next seven years as are young women of the same ethnic and socioeconomic background who have their first child between the ages of 20 and 24. The study was reported by Dr. Rosalind Y. Ting at the 1972 annual meeting in Washington, D.C. of the American Pediatric Society and the Society for Pediatric Research.

As part of the Philadelphia Collaborative Perinatal Study, 191 teenage black primigravidae and their children were compared with a matched group of primigravidae aged 20-24 and their children. Medical histories and examinations of the mothers showed that the only differences between them were that the teenage mothers had matured earlier than the older mothers, with 41 percent of them having achieved menarche at 11 years of age or younger, compared with 22 percent of the older mothers; the younger mothers had a somewhat more prolonged second stage of labor than the older group. There were no differences in the duration of prenatal care, number of pregnancy complications, incidence of toxemia, type of labor onset or delivery. Nor were there any differences in fetal factors or in infant mortality.

Neurological, psychological and IQ tests of the children done at various times in the first seven years showed only minor developmental differences. At four years and seven years their mean IQs were similar.

The teenagers appeared more mobile than the older women, with 40 percent of them moving three or more times in seven years, compared with 18 percent of the 20-24-year-old group.

The main difference, however, was that 24 percent of the teenage mothers went on to have three or more additional children within the seven years, compared to seven percent of the mothers aged 20-24.

Source

R.Y. Ting and M.H. Wang, "The Black Pregnant Teenager, What Becomes of Her and Her Offspring," paper presented at the annual meeting the American Pediatric Society and the Society for Pediatric Research, Washington, D.C., May 22-25, 1972.

Kit Recalled by FDA

A do-it-yourself pregnancy detection kit, Ova II, has been declared unreliable by the Food and Drug Administration (FDA) following laboratory tests of the kit's efficacy. The FDA announced that Ova II was being recalled at the request of the government agency from retail outlets all over the United States where it was said to have been selling briskly for $4.98 a kit. Ova II is distributed by Faraday Laboratories of Hillside, New Jersey.

Based on its evaluation of the kit, the FDA, in a statement issued to the media, warned consumers not to rely on the results of the home pregnancy test. "FDA believes the product to be inaccurate, unreliable and prone to give false results." It urged "any woman who has recently used Ova II as a pregnancy test to see her physician immediately for accurate methods of detecting pregnancy."

Faraday president Arnold Suresky maintained in a December 13 letter to distributors that the home test "is accurate and reliable when used as directed," but nonetheless asked that sales be discontinued and stocks be returned to Faraday.

A member of the FDA legal staff, Jeffrey Springer, told *Digest* that the watchdog agency is not "foreclosing home-type pregnancy kits, but simply has not yet found any that meet its standards." [For previous developments concerning Ova II and home pregnancy tests see: "Do-It-Yourself Kit Seized by FDA," *Digest*, Vol. 1, No. 4, 1972, p. 5.]

Sources

"Pregnancy Test Kits," news release No. 72-93, Food and Drug Administration, DHEW, Dec. 12, 1972.

A. Suresky, "Urgent: Product Recall," Faraday Laboratories, Dec. 13, 1972.

Family Planning Digest

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Family Planning Job Opportunities

Family planning agencies are invited to send job opportunity statements for professional positions to:

National Center for Family Planning Services
HSMHA, DHEW
5600 Fishers Lane, Room 12A-33
Rockville, Maryland 20852

The National Center for Family Planning Services, HSMHA, does not necessarily support the agencies seeking to fill positions.

All openings listed below are with Equal Opportunity employers.

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Position: Chief Clinician
Agency: Planned Parenthood Center, Inc.
Location: Syracuse, N.Y.
Salary: $30,000
Job Description: Work in family planning clinic offering such services as: contraception, laparoscopic sterilization, vasectomy and infertility workups, under supervision of part-time Medical Director. Opportunities for teaching, research and attendance at national meetings.
Qualifications: M.D., preferably obstetrician-gynecologist, licensed in New York State.
Contact: Ellen Fairchild, Executive Director, Planned Parenthood Center of Syracuse, Inc., 1120 East Genesee Street, Syracuse, N.Y. 13210. Phone: (315) 475-3193.

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Position: Program Director
Agency: Stanislaus Community Family Planning Program
Location: Modesto, Calif.
Salary Range: $12,000-$14,000
Job Description: Responsible for operation of main clinic and two satellite clinics, and for the continuing educational and community service aspects of the countywide program. Present staff consists of an R.N.-Clinic Supervisor, three outreach workers and several volunteers. In addition to administrative duties, the Program Director must organize various committees and attend meetings.
Qualifications: Strong administrative experience; writing skills; experience in the field of family planning.
Contact: Stanislaus Medical Society, 2030 Coffee Road, P.O. Box 1755, Modesto, Calif. 95354.

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Position: Family Planning Project Director
Agency: Perth Amboy General Hospital
Location: Perth Amboy, N.J.
Salary Range: $9,000-$11,000
Job Description: Initiate and coordinate family planning services of Perth Amboy General Hospital, Neighborhood Health Center and Planned Parenthood League in eastern Middlesex County.
Qualifications: College graduate or nursing program graduate with previous experience in administering and obtaining community involvement in health-related program.
Contact: Send resume to Director of Employee Relations, Perth Amboy General Hospital, Perth Amboy, N.J. 08861

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Position: Executive Director
Agency: Planned Parenthood of Metropolitan Washington
Location: Washington, D.C.
Salary: $16,000, or commensurate with experience
Job Description: Responsible for supervising staff and program. Make budget and policy recommendations to Board of Directors and implement its decisions, represent the agency with other public and private agencies, and be responsible for public relations. Is involved in fund-raising from public, government and private funding agencies.
Qualifications: B.A.; graduate education preferred but not required. A minimum of five years of professional employment, preferably in administration, community organization, public health, social welfare, family planning or education.
Contact: Mrs. Joseph L. Rauh, Jr., 3625 Appleton Street, N.W., Washington, D.C. 20008.

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Position: Deputy Director
Agency: Planned Parenthood of Monmouth County
Location: Red Bank, N.J.
Salary: $12,000
Job Description: Assist Executive Director with organizational coordination and operation. Supervise agency's internal fiscal and maintenance program. Monitor all fiscal matters relating to budgeting, cost accounting, purchasing, record-keeping, evaluation system and controls. Supervise outreach, education and medical programs.
Qualifications: Degree in business administration, with minor in public health or hospital administration, or at least three years' experience in the field of public health administration. Knowledge of principles and practices of volunteer agency operations helpful. A social worker with administrative training school background and corresponding work experience in fiscal administration also acceptable. Good interpersonal skills.
Contact: JoAnne Peterson, Executive Director, Planned Parenthood of Monmouth County, 141 Bodman Place, Red Bank, N.J. 07701.

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Position: Staff nurse (two openings, Brooklyn)
Agency: Planned Parenthood of New York City
Location: New York, N.Y.
Salary Range: $9,000-$9,500
Job Description: Interviewing, counseling, patient education. Services include contraception, vasectomy and VD screening.
Qualifications: R.N., licensed in New York State. Bilingual (English/Spanish) preferred. Obstetrical or public health or family planning experience.
Contact: Marion Levy, Planned Parenthood of New York City, 300 Park Avenue South, New York, N.Y. 10010.

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Position: Regional Director, Mid-Atlantic Region
Agency: Planned Parenthood-World Population
Location: Philadelphia, Pa.
Salary: Open
Job Description: Supervision of regional office staff and development of regional plans for meeting PP-WP five-year objectives. Coordination of program activities of regional affiliates. Serve as liaison to private, public, health and welfare agencies.
Qualifications: Degree in health or related field. Three years administrative experience. Ability to relate to volunteers and professionals.
Contact: Dorothea Lee, Field Director, 810 Seventh Avenue, New York, N.Y. 10019.

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